

Government and Medicine

Health Services in Saskatchewan

North America's First Comprehensive Government-Sponsored Health Plan

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AMERICAN PEOPLE are becoming increasingly disenchanted with their present system of health care. As costs have risen, services for many citizens have become progressively less available. Changes of major significance seem imminent and inevitable. The question currently being asked is not whether we shall have national health insurance in America; rather, it is what kind of national health insurance will we have.¹ There is growing national consensus that a system of health insurance covering not just old people or poor people but all people is needed. Various proposals which would transform the health care system are being considered currently by Congressional bodies.

Introduction of a system of comprehensive health insurance is hardly a new idea; indeed, most countries of the western world have already devised and implemented such arrangements. But in North America it was not until 1962 that the first comprehensive government-sponsored medi-

cal insurance program was instituted. This event occurred in Saskatchewan, Canada. In 1970, as representatives of the American Society of Internal Medicine, Richard Burg and I visited Saskatchewan to study its health care system and to learn how the people there regarded the program. Of the peoples of the world, Canadians are most like us. We share many cultural heritages and we have a common language, similar systems of government and an interdependent economy. Experience in Saskatchewan may provide information of value in predicting how comprehensive health insurance might be received in this country: Can we learn from their experience, capitalize upon their successes and avoid their mistakes?

Historical Perspectives

The Province of Saskatchewan is almost as large as Texas but has a population of only one million. Grain farming is the main industry. The climate is extreme and rigorous in both the meteorological and the political sense. The people of Saskatchewan remember very clearly the Great Depression of the 1930's. In 1937 two-thirds of the population were on relief and many people

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lived on the very edge of life. The crisis and suffering of these times demonstrated the collapse of an old economic order; as a child of deprivation, the Cooperative Commonwealth Federation (CCF), a new socialist political party, was born. The party, now called the New Democratic Party of Canada (NDP), is more Christian than Marxist in its ideology; it rallied together trade unionists, socialists, intellectuals and supporters of the Farmers Progressive Movement.²

For some years before 1962, many cooperative medical programs existed in Saskatchewan; some examples are the Hospital Services Plan, Workmen's Compensation Program, Mental Health Program, Cancer Clinics, and Air Ambulance Services. Among the territories of North America, Saskatchewan in 1962 was unusually advanced in its social consciousness; government was already involved in providing health services.

In April, 1959, Thomas C. Douglas, the CCF premier, announced the government's intention to introduce a comprehensive medical care insurance plan to cover the entire population of Saskatchewan. Through this program, all residents of the province would be eligible to receive medical services. It was emphasized that medical services would be of high quality. The program would be under the sponsorship of the provincial government and be administered by a commission responsible to the legislature and, through it, the entire populace. The services would be acceptable to those providing and to those receiving them. Services would be paid for with contributory premiums forming a part of the revenue. Other funds would be received from a sales tax and from federal sources. Payment for physician services generally would be on a fee for services basis.

In 1960, a bitterly contested provincial election was fought around the issue of government-financed comprehensive medical care, and the CCF government was re-elected. As the government prepared its plan to introduce the Medical Care Insurance Act, the physicians there generally prepared to oppose it. The government proceeded rapidly to introduce the act, with little or no consultation with the medical profession in spite of previous promises that this would be done. The government commission was given power which extended far beyond an insurance plan and gave the physicians neither rights nor privileges, no bargaining rights to negotiate fees and no privilege of advising the government in any way unless the commission agreed.³ On the other hand, the

physicians gave the Medical Care Act the most perverse interpretation conceivable.⁴ They aligned themselves with right wing political groups which associated their cause with cherished values; in so doing, they cultivated bigotry and prejudice.⁵ The physicians rejected the decision of the elected representatives of the people of Saskatchewan and failed to appreciate the constitutional rights and obligations of a minority group in a democratic society.⁴

Each side rejected the proposals of the other. The Medical Care Insurance Act became law on July 1, 1962, and on that date the physicians of Saskatchewan withdrew their services.

Public opinion became severely polarized. Rallies and marches attracting several thousand people were held for and against both sides. Tempers rose and fists flew during these weeks of a long hot summer. Extremists from both sides participated in violent and destructive behavior. Wheels inexplicably came off automobiles, physicians' cars were forced off the road, walls were daubed with paint and caustic substances were poured on lawns.

On July 23, 1962, after intensive negotiations mediated by Lord Stephen Taylor, the College of Physicians and Surgeons and the government agreed to what came to be called the Saskatoon Agreement. The government agreed to withdraw the controls over conditions of practice contained in the original legislation and indicated that it was not its intention to establish alternatives to fee for service as the method of remuneration to physicians. The government also agreed that non-profit insurance agencies would be preserved, though in modified form. Such was the stormy birth of the first comprehensive government-sponsored health insurance program in North America. In Canada, it is said that in the field of health care "what Saskatchewan does today, the rest of Canada will do tomorrow." Since 1962, government-sponsored health insurance systems covering hospitals and physicians services have been extended to virtually the entire population of Canada.

The Plan

The Medical Care Insurance Plan provides insurance coverage to Saskatchewan residents for almost all services by physicians, plus refractions by optometrists; chiropractic services will be covered in the near future. There is no limitation of

benefits. The plan is administered by a commission. With other programs such as the Hospital Services Plan, Psychiatric Services and the Cancer Commission, it forms part of Saskatchewan's health services.

A health insurance premium is levied annually and collected jointly with the hospitalization tax. The annual premiums are \$72 per family, of which \$24 is for the medical and \$48 for the hospitalization plan. The premium is waived for patients in financial need. The federal government contributes 65 percent of the costs of insured medical services provided; the balance is derived from the general revenues of the province. All beneficiaries under the plan receive the same coverage regardless of age or state of health.

In 1971 insurance payments for medical services were \$34,310,000; this amount was up by 12.2 percent from 1970. The costs of the Hospital Services Program in 1971 was \$90,517,400, an increase of 12 percent from the previous year. In 1963, the first complete year of operation of the medical care plan, the cost was \$18,330,000; the cost of the hospitalization plan in 1963 was \$43,706,000. The per capita utilization of medical services increased by 5 percent between 1970 and 1971, compared with a 3.6 percent average annual rate of increase between 1963 and 1971. Administrative costs of the medical care program in 1971 were 4.1 percent.⁶

The Medical Care Insurance Plan is administered by a commission consisting of not less than seven nor more than eleven members responsible to the Minister of Public Health. Three members are nominated by the College of Physicians and Surgeons of Saskatchewan. At present there are ten members, of which four are physicians; a physician is chairman.

How Physicians Are Paid

A physician receives payment in several ways. He may elect to submit a bill directly to the Government Insurance Commission and receive payment directly. Alternatively, if the patient is a member of one of the plans offered by the private nonprofit insurance agencies, the physician may bill the agency. The private agency then forwards the claim to the Insurance Commission, which recompenses the agency, and the agency then pays the physician. This arrangement was devised so that the physicians might choose to avoid having to negotiate directly with the government over money matters. In 1962, physicians wished to

avoid being paid directly by government because of the potential damage which might be caused to the doctor-patient relationship. A third method of billing involves the physician's sending the bill to the patient. The patient then negotiates with the government and the government sends the patient a check; the patient then pays the physician.

The existence of these alternative methods of billing was a concession made by the government to the physicians at the time of the Saskatoon Agreement. In 1962, direct billing to the Government Insurance Commission was regarded by the profession as undesirable. Since 1962, however, there has been progressive acceptance of direct billing by the profession. Approximately 60 percent of all accounts are now sent directly to the Insurance Commission. The method of payment through private insurance agencies is a highly artificial system which reduces the function of these agencies to little more than that of a post-office service. Billing the patient and having him secure reimbursement from the government was advocated initially by some of the strongest opponents of the government plan; but it was discovered that patients might receive and spend the check and then indicate that they were unable to pay the bill. Billing the patient directly is not popular with the physicians.

The Medical Care Plan receives more than 65,000 claims each week for physicians, private health agencies, optometrists and patients. Information from the claim is transferred to key-punched cards which are scanned by a computer where the claim is subjected to a series of tests which determine if the account can be approved for immediate payment. The proportion of claims that fail to pass the tests is small; among the chief reasons for failure are that the patient's name, age or sex does not correspond with his health insurance number. One percent of accounts are duplicates and have been submitted and paid previously.

The College of Physicians and Surgeons and the government negotiate schedules of payment for physician services. In this bargaining process the strength lies with the government because it has ultimate fiscal responsibility. Bills rendered by the physician for payment by the commission must itemize the services given. As a consequence, an extraordinary wealth of information is available about particular services that the various types of physicians provide to the public.

Incomes of physicians have increased. Special-

ists are paid at the specialty rate if the patient is referred by another physician; he is paid as a generalist when he sees patients who are not referred.

The number of registered physicians in Saskatchewan has increased from 633 in 1950 to 895 in 1960 and 1,019 in 1970. There has been a progressive decline in the number of new registrants from Canadian medical schools and an increasing registration of foreign physicians. Saskatchewan has reciprocity with the General Medical Council of Great Britain. At present, approximately one-half of the new registrants are graduates of British medical schools.

Review of Professional Services

In 1964 at the request of the Insurance Commission, a Professional Review Committee (PRC) was appointed by the College of Physicians and Surgeons to study and analyze cost-related data. There are seven members; all are physicians. Various factors in each physician's practice (a "profile") are assembled quarterly and provide information about the amount and cost of services he provides. Analysis of the quality of care cannot be made from the "profile."

The medical branch of the Insurance Commission devises and formulates most of the studies which are referred to the PRC. Examination of the profiles reveals great variation in the services provided; some physicians, for example, order many electrocardiograms while others practicing in apparently similar circumstances order only a few. When a physician deviates by more than two standard deviations from the mean of others in the same category, his profile is referred to the PRC. In some instances there are obvious and legitimate reasons for the deviation—the physician may have a small referral practice and sees patients with complicated problems which require extensive and costly investigation. In other instances, reasons for deviation may not be apparent. The PRC may interview physicians and invite them to explain why their costs of patient care are significantly different from those of their peers. In instances where physicians seemed to be involved in providing an unjustifiable number of particular service items, the College has approved payment to these physicians at a reduced rate for these items.

A second kind of study examines the cost of a particular service; for example, nearly all bills for appendectomy indicated that "complications"

had occurred. When medical records were examined, existence of complications could not be confirmed. The original payment schedule listed "appendectomy" and "complicated appendectomy" and assigned a higher fee for the latter. The schedule was subsequently revised to list only "appendectomy" (with or without complications).

The PRC has maintained a fluctuating level of activity; its energies have been directed toward investigating cost factors. There has been no significant study of the quality of medical care. The PRC reports and make recommendations to the College of Physicians and Surgeons. The College has varied in its responsiveness, but since 1970 it has supported the PRC more actively.

Attitudes Toward the Program

We asked many members of the general public if they would choose to return to the former ways of providing medical care insurance. The question was usually regarded as being ridiculous; "Of course not," was the usual reply. We asked people how much the health plan insurance cost them. Many seemed surprised at the question; others gave as their answer the amount of the annual premium. Few individuals had any idea of how much the program was costing them. The relationship of the sales tax to the health care scheme was usually forgotten, as was the federal contribution, derived to a large extent from federal income taxes.

Nurses and laboratory technicians were questioned. All agreed that the medical care program was popular with the general public. They expressed the opinion that the only opposition to the program lies with older physicians. Interviews with three social workers were of particular interest. They insisted that medical services were just as available to persons in economically deprived circumstances as to anyone else.

Several physicians were interviewed. Among older physicians and especially those who were directly involved in the dispute of 1962, resentment and bitterness lingers. They voiced suspicion that the Insurance Commission planned to extend their control over the practice of medicine, abolish fee for service remuneration and even direct physicians to practice in particular geographic areas of the province. Many young physicians, however, regarded the health insurance commission as a non-controversial part of their way of life.

Several members of the Department of Public Health of Saskatchewan were interviewed. All saw

an urgent need to control the rising costs of providing health care and were concerned that the general public had been "educated" to expect so much from the health care system. Only 3 percent of the budget is spent on preventive health and health education. We inquired about the concern which physicians expressed regarding government interference with their practices and their inability to influence when or how the rules which govern these activities might change. Representatives of the government indicated that it was very unlikely that the government would move in a unilateral manner which would adversely affect a profession whose practitioners are in short supply.

There can be no doubt of the popularity of the medical care insurance plan in Saskatchewan; the public strongly supports it and there is no significant opposition to it. If there was any major feeling against the program, at least one of the political parties would have adopted as part of their platform a resolution to restrict or rescind the program. All major political parties in Saskatchewan have endorsed the program and since 1962 every provincial government in Canada has adopted a program of health insurance. The federal government has encouraged these activities by providing funds to share the costs of such programs.

Discussion

The major problems facing the Saskatchewan plan are over-utilization of services by the patient, over-servicing by the physician, and escalating costs. In an effort to curb over-utilization, the Liberal government in 1968 introduced "utilization" or "deterrent" fees. The amount of the fee paid by the patient was \$1.50 per office visit and \$2.00 per home visit. A fee of this size does not represent a major deterrent except to those in economically deprived circumstances; the fees were abandoned in 1971.

Over-utilization is difficult to define in practical terms. If the utilization of preventive health service could be increased, the need for conventional services might be reduced. The development of a truly healthy society requires that social, cultural and educational barriers be surmounted. The ultimate target is a service oriented to health as well as to disease; the Saskatchewan program remains conventionally directed to disease.

Over-servicing by physicians continues to be scrutinized by the Professional Review Committee of the College. In Saskatchewan, pressure by government upon the College of Physicians was re-

quired to make the review process even minimally effective. But concern about over-servicing is not restricted to agencies of the government. One physician put it this way: "The Plan encourages the 'demoralization' of the physician. Inevitably when a doctor has a scheme that will pay for services rendered, including investigations, he will lean toward doing extra things and ordering extra tests to ensure that he is not missing something in the diagnosis. He is especially likely to over-service if, by so doing, he increases his income."

Escalating costs are a major concern; it is likely that the government will encourage the development of experimental modules to determine how the quantity of health care delivery might be increased and made more effective while at the same time reducing costs. These may include plans similar to health maintenance organizations currently being developed in this country.

It also seems likely that different ways of paying the physician will be tested. Thus far, the fee for service principle has been preserved as the usual basis for physician remuneration. One physician had this to say: "In Saskatchewan, nobody at the moment is thinking much about a salaried service. But the fee for service principle here and in the United States is in jeopardy because, in some instances, fees are not realistic. When a large third party pays fees, they take a much closer look than individual patients. Unless physicians in practice recognize this and permit adjustment of the fee structure, the fee principle will disappear." The words "experiments in capitation fees" and "experiments with salaried physicians" were heard in several places, but always somewhat *sotto voce*.

An important "lesson" may be learned from the stormy days of 1962 when the government of Saskatchewan and the College of Physicians and Surgeons of Saskatchewan were locked in what was seen as a battle for survival. At the height of this conflict communication between the combatants ceased and polarization of the general public was encouraged by both sides. It is testimony to the emotional stability and maturity of the people of Saskatchewan that so few signs of the battle remain. The need to maintain lines of communication between disagreeing groups is essential. Can we learn from the experience of Saskatchewan?

In retrospect, it is interesting to speculate as to why the government pushed ahead with plans to introduce the Medical Care Insurance Act with so little consultation with the physicians. Such

a course of action together with the controls over physicians proposed in the original legislation seemed certain to generate intense opposition by the physicians and to guarantee a major confrontation between the Saskatchewan government and the College of Physicians and Surgeons. Was this course of action accidental or deliberate? Was the confrontation planned so that the power of the College of Physicians and Surgeons to influence the shape of the health care system would be reduced? The College, by signing the Saskatoon Agreement, won several concessions from the government; but it also accepted that physicians in Saskatchewan henceforward would serve in and accept a compulsory, universal medical service plan administered by the provincial government. It is difficult to imagine the College agreeing to such an arrangement under any other circumstances than a major public confrontation.

Political history in this country indicates that social changes are brought about by "tinkering" with the system rather than by major confrontation. If a system of government-sponsored comprehensive health care is instituted, it will not occur without significant opposition from orga-

nized medicine. Will proponents of such a plan try to win the physicians' stronghold by scaling its walls and doing open battle as in Saskatchewan? Or will they try to take the bastion from the inside, little by little, program by program?

Opponents of government-sponsored comprehensive health insurance programs may say that "Americans would never accept socialized medicine." But Saskatchewan, Canada, is a territory adjacent to our own country and is inhabited by a people similar to us in many ways. In Saskatchewan since 1962 socialized medicine has been a popular and non-controversial part of the way of life. It is, however, hardly "what the doctor ordered."

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